

FAUQUIER COUNTY GOVERNMENT AND PUBLIC SCHOOLS  
 ANTHEM BLUE CROSS AND BLUE SHIELD  
 MEDICAL INSURANCE AND PRESCRIPTION DRUG BENEFIT SUMMARY OVERVIEW  
 EFFECTIVE JULY 1, 2005

**KeyCare Plans**

*Preferred Provider Organization (PPO)* – The KeyCare PPO Plans provide a large network of providers and hospitals which members can access. The KeyCare Plans do not require referrals and provide both In-Network and Out-of-Network benefits. When utilizing the KeyCare benefits on an In-Network basis, members will typically pay copays and/or coinsurance. If members utilize their Out-of-Network benefits, they will first need to satisfy their calendar year deductible and then they will be reimbursed the applicable coinsurance level. Please be aware when members are using their Out-of-Network benefits, members must obtain the necessary prior authorizations for certain procedures and testing. A brief summary of the Out-of-Network benefits are listed at the bottom of the outline below; however, detailed information on the Out-of-Network benefits is available upon request.

**HealthKeepers Plan**

*Health Maintenance Organization (HMO)* - The HealthKeepers HMO Plans provide rich benefits with fixed copays. The HealthKeepers Plans require the selection of a Primary Care Physician (PCP) who will coordinate all of the member's care. When accessing care from a provider other than the member's PCP, HealthKeepers members must attain a referral from their PCP. If a member does not attain the necessary referral, the services will not be covered under the HealthKeepers Plans.

As you review the outline of benefits for the plans, keep in mind that an important aspect of saving on your Out-of-Pocket medical expenses is using the appropriate network of Anthem Blue Cross and Blue Shield providers in the plan you select.

**Unmarried dependants are covered until the end of the calendar year they turn 19; or until the end of the calendar year they turn 23, if they are a full-time student.**

<b>MEDICAL INSURANCE</b>	<b>KEYCARE 10</b> <i>Copayment (program pays)</i>	<b>KEYCARE 15</b> <i>Copayment (program pays)</i>	<b>KEYCARE 300</b> <i>Deductible (program pays)</i>	<b>HEALTHKEEPERS 20</b> <i>Copayment (program pays)</i>
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum (stop-loss)***	\$1,000 per individual; \$2,000 per family	\$2,000 per individual; \$4,000 per family	\$2,000 per individual; \$4,000 per family	\$1,500 per individual; \$3,000 per family
Deductible	None	None	\$300 per member/\$600 per family	none
<b>INPATIENT SERVICES</b>				
Inpatient	No maximum number of days	No maximum number of days	No maximum number of days	No maximum number of days
Inpatient Hospital	90% of AC* after \$200 per confinement copayment	80% of AC* after \$300 per confinement copayment	80% of AC*	100% of AC* after \$200 per day copayment (\$1,000 maximum copay per admission)
Inpatient Provider/Doctor	90% of AC	80% of AC	80% of AC	100% of AC
Mental Health Inpatient	90% of AC after \$200 copayment	80% of AC after \$300 copayment	80% of AC	100% of AC after per day copayment
Skilled Nursing Facility	90% of AC (100 days per confinement)	80% of AC (100 days per confinement)	80% of AC	100% of AC (100 days per illness)
Pre-Hospital Admission	Call 1-800-242-7277	Call 1-800-242-7277	Call 1-800-242-7277	Done by Primary Care Physician
<b>PROVIDER SERVICES</b>				
Primary Care Physician	Not required	Not required	Not Required	Required
Referral for Specialist	Not required	Not required	Not Required	Required

<b>MEDICAL INSURANCE</b>	<b>KEYCARE 10 (program pays)</b>	<b>KEYCARE 15 (program pays)</b>	<b>KEYCARE 300 (program pays)</b>	<b>HEALTHKEEPERS 20 (program pays)</b>
<b>OUTPATIENT EXPENSES</b>				
Physician/Primary Care Office Visit	100% of AC after \$10 copay	100% of AC after \$15 copay	80% of AC	100% of AC after \$20 copay
Specialist Office Visit	100% of AC after \$20 copay	100% of AC after \$30 copay	80% of AC	100% of AC after \$40 copay
Diagnostic Testing	90% of AC	80% of AC	80% of AC	100% of AC after \$40 copay if not done at time of office visit
Facility/Surgery (SPU)	90% of AC after \$100 copay	80% of AC after \$100 copay	80% of AC	\$200 copay
Mental Health	100% of AC after \$10 Physician/\$20 Specialist copay – no visit limit	100% of AC after \$10 Physician/\$20 Specialist copay – no visit limit	80% of AC	100% of AC after \$20 copay grp therapy and indivl therapy up to 30 minutes after med mgmt, then \$30 all other visits
<b>WELL BABY CARE</b> (until the day the child turns 7)	100% of AC after \$10 Physician/\$20 Specialist copay	100% of AC after \$15 Pysician/\$30 Specialist copay	80% of AC	100% after \$20 copay
Immunizations	100% of AC	100% of AC	80% of AC	100% of AC
<b>ROUTINE WELLNESS</b>	<b>(\$150/CY)</b>	<b>(\$150/CY)</b>		
Routine visits	100% of AC after \$10 copay	100% of AC after \$15 copay	80% of AC	100% of AC after \$20 copay
Routine labs/x-rays	90% of AC	80% of AC	80% of AC	100% after \$20 copay if not done at time of office visit (\$100 copay for MRI, MRA, PET scans)
Colorectal Cancer Screening	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received	80% of AC	Copayment/coinsurance determined by service received
<b>WELL WOMEN EXAM</b>				
Routine GYN Exam (1/CY)	100% of AC after \$10 Physician/\$20 Specialist copay	100% of AC after \$15 Physician/\$30 Specialist copay	80% of AC	100% after \$20 copay (referral not necessary; must choose from specialist list)
Mammograms	90% of AC	80% of AC	80% of AC	100% of AC after \$20 copay if not done at time of office visit
Pap Smears	90% of AC	80% of AC	80% of AC	100% of AC
<b>MATERNITY</b>				
Pre and Post Natal Care	100% of AC after \$10 Physician/\$20 Specialist copay	100% of AC after \$15 Physician/\$30 Specialist copay	80% of AC	100% of AC after \$200 copay per pregnancy
Diagnostic Testing	90% of AC	80% of AC	80% of AC	100% of AC after \$40 copay
<b>EMERGENCIES</b>				
Emergency Room, Accidents, Medical Emergencies	Facility - 90% of AC after \$100 copay. Doctor - 100% of AC after \$10 Physician /\$20Specialist c pay	Facility - 80% of AC after \$100 copy Doctor - 100% of AC after \$15 Physician/\$30 Specialist copay	80% of AC	100% of AC after \$100 copay (member must contact their PCP within 48 hours after receiving care)
Urgent Care Services	100% of AC after \$10 Physician/\$20 Specialist copay	100% of AC after \$15 Physician/\$30 Specialist copay	80% of AC	100% of AC after \$50 copay
<b>OTHER SERVICES</b>				
Physical Therapy, or Occupational Therapy	100% of AC after \$10 Physician/\$20 Specialist copay (\$2,000 maximum / CY for PT and OT)	100% of AC after \$15 Physician/\$30 Specialist copay (\$2,000 maximum / CY for PT and OT)	80% of AC (\$2,000 maximum / CY for PT and OT)	100% of AC after \$25 copay**
Private Duty Nursing	80% of AC (\$500 max / CY)	80% of AC (\$500 max / CY)	80% of AC (\$500 max / CY)	Not covered
Medical Equipment	80% of AC (\$5,000 max / CY)	80% of AC (\$5,000 max / CY)	80% of AC (\$5,000 max / CY)	100% of AC (\$2,000 max per CY)
Ground Ambulance Services	80% of AC (\$3,000 max / CY)	80% of AC (\$3,000 max / CY)	80% of AC (\$3,000 max / CY)	100% of AC (must be pre-authorized, pre-authorization not required if an emergency)
Speech Therapy	80% of AC after \$10 Physician/\$20 Specialist copay (\$500 max/ CY)	80% of AC after \$15 Physician/\$30 Specialist copay (\$500 max/ CY)	80% of AC (\$500 max/ CY)	100% of AC after \$25 copay**

<b>MEDICAL INSURANCE</b>	<b>KEYCARE 10</b> (program pays)	<b>KEYCARE 15</b> (program pays)	<b>KEYCARE 300</b> (program pays)	<b>HEALTHKEEPERS 20</b> (program pays)
<b>ROUTINE VISION</b> (Davis Vision Network)	100% of AC after \$15 copay; Annual contact lens fitting \$25 copay (discounts on frames and lenses)	100% of AC after \$15 copay; Annual contact lens fitting \$25 copay (discounts on frames and lenses)	100% of AC after \$15 copay, Annual contact lens fitting \$25 copay (discounts on frames & lenses)	100% of AC after \$10 copay, Annual Contact Lens fitting \$25 copay (discounts on frames & lenses)
<b>OUT-OF-NETWORK BENEFITS</b>	Calendar Year Deductible - \$200/\$400 Coinsurance – 70% of AC after Ded. Out-of-Pocket Max. - \$2500/\$5000	Calendar Year Deductible - \$400/\$800 Coinsurance – 70% of AC after Ded. Out-of-Pocket Max. - \$4000/\$8000	Calendar Year Deductible - \$450/\$900 Coinsurance – 60% of AC after Ded. Out-of-Pocket Max. - \$3000/\$6000	Emergency Coverage Only

<b><i>PRESCRIPTION DRUG PROGRAM</i></b> <i>(employee pays)</i>		
	Up to 31-day Medication Supply <i>(From Retail Pharmacy)</i>	Up to 90-day Medication Supply <i>(Maintenance Medications through Home Delivery Service)</i>
Tier 1 Medications	\$10 copay	\$20 copay
Tier 2 Medications	\$20 copay after deductible	\$40 copay after deductible
Tier 3 Medications	\$35 or 20% of script cost (\$200 per script maximum) after deductible	\$70 or 20% of script cost (\$400 per script maximum) after deductible
Deductible (Tiers 2 & 3 Only)	\$150 per member/\$300 per family	
Out-of-Pocket Maximum	\$3500 per member	
<b>All plans include MANDATORY GENERIC &amp; FDA approved contraceptives and devices</b>		

\* AC - allowable charge

\*\* Visits are limited to 90 days (combined for inpatient and outpatient visits) from the first day of treatment for a condition or illness.

\*\*\*Out-of-Pocket Maximum (Stop-Loss) - You and the plan share copayment responsibilities only up to the annual Out-of-Pocket Maximum. Beyond that limit, the plan covers 100% of allowable charges for covered services through the end of the calendar year. The annual Out-of-Pocket Limit for your plan is indicated above for each plan being offered. Please reference your handbook for expenses that apply toward the Out-of-Pocket Maximum.

**Please be advised this is an illustrative summary for informational purposes only. The applicable Medical Plan Booklet will be distributed to all employees who enroll in the health care program. The aforementioned Medical Plan Booklet will provide a thorough description of your benefit plan.**

<b>Customer Service Toll Free Number:</b>	<b>KeyCare:</b>	<b>1-800-451-1527</b>
	<b>HealthKeepers:</b>	<b>1-800-421-1880</b>